



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

COVENANT MEDICAL CENTER
PO BOX 1866
FORT WORTH TX 76101

Respondent Name

MIDLAND COUNTY

MFDR Tracking Number

M4-08-2188-02

DWC Claim #:

Injured Employee:

Date of Injury:

Employer Name:

Insurance Carrier #:

Carrier's Austin Representative Box

#55

MFDR Date Received

November 13, 2007

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The medical dispute I have requested is due to the stop loss clause. The bill exceeded \$40,000.00 therefore should pay at 75% of billed charges."

Amount in Dispute: \$39,372.40

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated December 21, 2007: "The Requestor seeks additional reimbursement under the Acute Care Inpatient Hospital Fee Guidelines. The Requestor has invoked the Stop-Loss provision of Rule 134.401 and seeks additional reimbursement in the amount of \$39,372.40 for a four-day stay. According to the DWC-60, the Requestor billed \$69,811.20, and the Respondent paid \$12,986.00"

Respondent's Supplemental Position Summary dated September 8, 2011: "In light of the November 2008 Austin Court of Appeals decision regarding the interpretation of the Stop-Loss Rule, the Division has provided us with the opportunity to supplement the original response."

Responses Submitted by: Harris & Harris

Respondent's Additional Information dated September 22, 2011: "I have reviewed the MFDR file, which contains the Carrier's original response...I do not believe a supplement is needed to the response."

Additional Response submitted by: Christopher Ameal, Attorney at Law, PLLC

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
June 27 to July 1, 2007	Inpatient Hospital Services	\$39,372.40	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.240, 31 *Texas Register* 3544, effective May 2, 2006, sets out the procedures for medical payments and denials.
2. 28 Texas Administrative Code §133.2, 31 *Texas Register* 3544, effective May 2, 2006, sets out the definition of final action.
3. 28 Texas Administrative Code §133.305 and §133.307, 31 *Texas Register* 10314, applicable to requests filed on or after January 15, 2007, sets out the procedures for resolving medical fee disputes.
4. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits

- W1 – Workers compensation state fee schedule adjustment.
- 97 – payment is included in the allowance for another service/procedure
- 42 – charges exceed our fee schedule or maximum allowable amount
- Surgical per diem applied

Dispute M4-08-2188 was originally decided on September 12, 2008 and subsequently appealed to a contested case hearing at the State Office of Administrative Hearings (SOAH) under case number 454-09-1746.M4. This dispute was then remanded to the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) pursuant to a February 16, 2009 SOAH order of remand. As a result of the remand order, the dispute was re-docketed at medical fee dispute resolution and is hereby reviewed.

Issues

1. Did the audited charges exceed \$40,000.00?
2. Did the admission in dispute involve unusually extensive services?
3. Did the admission in dispute involve unusually costly services?
4. Is the requestor entitled to additional reimbursement?

Findings

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 *Texas Register* 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed \$40,000 and that an admission involved unusually costly and unusually extensive services." Both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each was given the opportunity to supplement their original MDR submission, position or response as applicable. The documentation filed by the requestor and respondent to date will be considered in determining whether the admission in dispute is eligible for reimbursement under the stop-loss

method of payment. Consistent with the Third Court of Appeals' November 13, 2008 opinion, the division will address whether the total audited charges **in this case** exceed \$40,000; whether the admission and disputed services **in this case** are unusually extensive; and whether the admission and disputed services **in this case** are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that "Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as described in paragraph (6) of this subsection..." 28 Texas Administrative Code §134.401(c)(6) puts the requirements to meet the three factors that will be discussed.

1. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states "...to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed \$40,000, the minimum stop-loss threshold." Furthermore, (A) (v) of that same section states "...Audited charges are those charges which remain after a bill review by the insurance carrier has been performed..." Review of the explanation of benefits issued by the carrier finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore the audited charges equal \$69,811.20. The division concludes that the total audited charges exceed \$40,000.
2. The requestor's position statement asserts "The bill exceeded \$40,000.00 therefore should pay at 75% of billed charges." In its position statement, the requestor presupposes that it is entitled to the stop loss method of payment because the audited charges exceed \$40,000. As noted above, the Third Court of Appeals in its November 13, 2008 rendered judgment to the contrary. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed \$40,000 and that an admission involved...unusually extensive services." The requestor failed to discuss the particulars of the admission in dispute that may constitute unusually extensive services; therefore, the division finds that the requestor did not meet 28 TAC §134.401(c)(6).
3. In regards to whether the services were unusually costly, the requestor presupposes that because the bill exceeds \$40,000, the stop loss method of payment should apply. The third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must **demonstrate** that an admission involved unusually costly services thereby affirming 28 Texas Administrative Code §134.401(c)(6) which states that "Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker." The requestor failed to discuss the particulars of the admission in dispute that may constitute unusually costly services, therefore, the division finds that the requestor failed to meet 28 TAC §134.401(c)(6).
4. For the reasons stated above the services in dispute are not eligible for the stop-loss method of reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount* and §134.401(c)(4) titled *Additional Reimbursements*. The division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.
 - Review of the submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of \$1,118.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission..." The length of stay was four days. The surgical per diem rate of \$1,118.00 multiplied by the length of stay of four days results in an allowable amount of \$4472.00.
 - 28 Texas Administrative Code §134.401(c)(4)(C) states "Pharmaceuticals administered during the admission and greater than \$250 charged per dose shall be reimbursed at cost to the hospital plus 10%. Dose is the amount of a drug or other substance to be administered at one time." A review of the submitted itemized statement finds that the requestor billed Thrombin vial 20,000 . The requestor did not submit documentation to support what the cost to the hospital was for Thrombin vial 20,000. For that reason, reimbursement for this item cannot be recommended.
 - The division notes that Texas Administrative Code §134.401(c)(4)(A), states "When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274)." Review of the requestor's medical bills finds that the following items were billed under revenue code 0278 and are therefore eligible for separate payment under §134.401(c)(4)(A) as follows:

Ref. Num.	Itemized Statement Description	Cost Invoice Description	UNITS / Cost Per Unit	Total Cost	Cost + 10%
01105509	Cap locking 3-D head	TI click x locking cap for 3-D head	5 @ \$ 160.00	\$ 800.00	\$ 880.00
01105511	Screws click 3-D head	TI 3-D head for TI click X screws	4 @ \$ 360.00	\$1440.00	\$1584.00
01106194	Putty DBX 5cc	5cc DBX putty	1 @ \$ 780.00	\$ 780.00	\$ 858.00
01314090	6.2mm x 40mm pedicle screw	6.2mm TI click X pedicle SCR dual core	2 @ \$ 380.00	\$ 760.00	\$ 836.00
01316571	Rod soft 6.0 x 45mm curved	6.0mm TI curved soft rod 45mm	2 @ \$ 100.00	\$ 200.00	\$ 220.00
01317822	Click x pedicle screw	5.2mm TI click X pedicle SCR dual core	2 @ \$ 380.00	\$ 760.00	\$ 836.00
01317851	Vertebral spacer 7x10x27mm	Vertebral spacer	1 @ \$1800.00	\$1800.00	\$1980.00
TOTAL ALLOWABLE				\$7194.00	

The division concludes that the total allowable for this admission is \$4472.00 per diem plus \$7194.00 implantables for a total of \$11,666.00. The respondent issued payment in the amount of \$12,986.00. Based upon the documentation submitted, no additional reimbursement can be recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed \$40,000, but failed to discuss and demonstrate that the disputed inpatient hospital admission involved unusually extensive and unusually costly services. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount* and §134.401(c)(4) titled *Additional Reimbursements* are applied and result in no additional reimbursement.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the division has determined that the requestor is entitled to \$0.00 additional reimbursement for the disputed services.

Authorized Signature

_____	_____	October 2012
Signature	Medical Fee Dispute Resolution Officer	Date

_____	_____	October 2012
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.